STATEMEN	IT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	TOWN	TID1	E CONSTRUCTION		<u>). 0938-0</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				TE SURVEY MPLETED
		445264	B, WING			ns	/15/2013
NAME OF	PROVIDER OR SUPPLIER		<del> </del>	57	TREET ACCRESS, CITY, STATE, ZIP COD	E	71012010
LAUGHI	IN HEALTH CARE CE	NTER			01 E MCKEE ST REENEVILLE, TN 37743		1
(X4) 1D	SUMMARY STA	TEMENT OF DEFICIENCIES	1 10		PROVIDER'S PLAN OF CORRE	CTION	1 (X5)
PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG	Υ	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE PROPRIATE	COMPLE DATE
F 000	INITIAL COMMENT	·c	FO	00	Laughlin Healthcare Center acknowledges that during the	A	
	WITH THE OBJAINIE   THE		l Fu	וטט	Recertification Survey and Con		ŀ
	An annual receptifie	ation and complaint		- 1	Investigation #32026, complete		
	investigation #32026	ation and complaint  were completed on August			August 15, 2013, no deficiencie		
,	15, 2013, at Laughli	n Health Care Center. No			cited related to the complaint		
	deficiencies were cit	ted refated to complaint		- 1	investigation #32026 under 42		!
	Investigation #32026	6 under 42 CFR Part 483,		-	483, Requirements for Long To	erm Care	}
E 164	Requirements for Lo	ong Term Care Facilities.			Patmites.		
C 104	483.10(e), 483.75(l)	NTIALITY OF RECORDS	F 16	34	483.10(e), 483.75(l)(4) F 164 P	ERSONAL	}
33-0	1 MANO I CONFIDE	MIALIT OF RECORDS		- [	PRIVACY/CONFIDENTIALI	TY OF	
	The resident has the	right to personal privacy and			RECORDS	·	1
	confidentiality of his	or her personal and clinical		Ì	THE ANTONIA CONT. 99		· ·
	records.			ŀ	REQUIREMENT: The resident right to personal privacy and com		
. 1	Personal estration	h.d.,			of his or her personal and clinical	records.	
ľ	medical freatment, w	udes accommodations,			,		
İ	communications, per	rsonal care, visits, and			Personal privacy includes accom-		]
1	meetings of family ar	nd resident groups, but this			medical treatment, written and te	lephone	1
}	does not require the	facility to provide a private		ĺ	communications, personal care, v meetings of family and resident g	risits, and	
J	room for each reside	nt.			this does not require the facility to	goups, om o mrovide:a	
1	Event on provided :-			ſ	private room for each resident.	, o b) o 17ac u	Ì
- 1	Except as provided it section, the resident	n paragraph (e)(3) of this may approve or refuse the					}
	release of personal a	nd clinical records to any	•		Except as provided in paragraph (	(e)(3) of	
	individual outside the	facility.			this section, the resident may app	rove or	
	The market are being				refuse the release of personal and records to any individual outside		
	ı ne resident's right to	refuse release of personal			way marrana validate	шо лисину.	!
	esident is transferrer	oes not apply when the			The resident's right to refuse rele		
		elease is required by law.		-	personal and clinical records does	not apply	l
- 1	•	·			when the resident is transferred to		
	The facility must keep	confidential all information			health care institution; or record r required by law.	cicase is	
	xontained in the resid	ent's records, regardless of lethods, except when			valuetan Al vent		
	elease is required by				The facility must keep confidentia	al all	
j	ealthcare institution:	law; third party payment			information contained in the resid	lent's	
	contract; or the reside	ent.			records, regardless of the form or	storage	
					Continue to page 2 of 19	Í	
RATORY P	HRECTOR'S OR PROVINCE	SUPPLIER REPRESENTATIVE'S SIGNA	CORE		TITLE	<u>:                                    </u>	XB) DATE

TITLE

(XB) DATE

- B.B.A-MUNSUA HOAR ADMINISTRATION Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

			ULTIPLE CONSTRUCTION LDING		E SURVEY PLETED	
		445264	B. WING		ns/	15/2013
LAUGH	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT!  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 241	This REQUIREMENT by: Based on observation failed to maintain conformation for one of residents reviewed. The findings includes Resident #4 was add 17, 2010, with diagn Mellitus, Alzheimer's Obstruction, Urinary and Chronic Pain. Observation during a 2013, at 3:00 p.m., in revealed Licensed P seated in the Assistate (ADON) Office with the ADON office with the ADON office. Continued observation a wheelchair behind the ADON office. Conceeded the resident of LPN #2 and the ADON at clinical status of resident linearies with LPN #23:10 p.m., in the east	on and interview, the facility infidentiality of medical resident (#4) of thirty  d: mitted to the facility on June oses including Diabetes Disease, Chronic Airway Tract Infection, Depression,  a staff interview on August 13, a the east wing dining area ractical Nurse (LPN #2) int Director of Nursing's he ADON. Continued the ADON and LPN #2 all history and diagnoses of eviewed the medical record. In revealed a resident seated of LPN #2 and the ADON in intinued observation peered over the shoulders DON and viewed the open and LPN #2 discussed the lent #4.  It on August 13, 2013, at wing dining room confirmed to protect confidentiality of resident #4.	F 241	methods, except when release is requiransfer to another healthcare instituted law; third party payment contract; or resident.  POC:  1. LPN was provided in-service econs/27/13 regarding maintaining confidentiality of Medical Recoording patient confidentiality. This will be confidentiality. This will be confidentiality. This will be confidentiality of individual resistence education regarding the confidentiality policy, with empleconfidentiality of individual resistence.  4. The DON, ADON and nurse may will monitor for compliance during daily observation and follow-up findings will be addressed in the Monthly QA Meetings.  September 18 of 18	vired by tion; r the lucation lg rds. service upleted in- facility hasis on dent nagers ing	2013
ا تا-دیق			•	RESPECT OF INDIVIDUALITY  Continue to page 3 of 19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<u> </u>
		445264	B. WING		0014512042	
	PROVIDER OR SUPPLIER JN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743	08/15/2013	_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE COMPLETION	N N
	manner and in an elenhances each residents (#85), #86, and the west wing nurse's residents (#85), in the residents (#85) in the residents (#85) in the resident	mote care for residents in a hylronment that maintains or dent's dignity and respect in a for her individuality.  T is not met as evidenced on and interview, the facility environment to maintain and six of thirty-four residents  It is 12, 2013, at 12:30 p.m., at a station revealed five #35, #42, #66) sitting in front in the hallway eating lunch.  It is 13, 2013, at 8:15 a.m., at a station revealed five #35, #42, #66) sitting in the nurse's station eating  at 13, 2013, at 8:30 a.m., at station revealed one hallway in front of the nurse's st.  5, 2013, at 10:30 a.m., at station with Licensed #1) revealed the residents ecause there was not	F 24	REQUIREMENT: The facility me promote care for residents in a many in an environment that maintains or enhances each resident's dignity and in full recognition of his or her indifferent of the nursing stations for have been interviewed and all it insist that they remain in the half sitting in front of the nursing stations for have been interviewed and all it insist that they remain in the half sitting in front of the nursing stationing, and this is resident right resident choice. Resident #86 It moved into the West Wing smarroom for dining.  2. New admissions will be encourse eat in main dining room unless indicated by safety issues. If sa issue is a concern, the patient we placed in small dining room and encouraged to have all meals in area.  3. The area in the hallways in from nursing stations will now be designating stations will now be designating the area as an extense the dining room. Appropriate ta will be added to the area during the DON, ADON, Wing Managand/or designees will assess resion admission for safest diving ar will be placed appropriately. Curesidents will be encouraged to esmall dining areas but their choice small dining areas but their choice small dining areas but their choice.	mer and d respect viduality.  way in dining out # 86 illway ation for and has been all dining aged to contra- fety ill be that t of the dignated a sign rooms sion of ables dining gers dents rea and arrent ext in	
fe	nough room in the si continued interview wacility had failed to man	ith LPN #1 confirmed the aintain the resident's		rights will be honored. Current residents in dining area have bee Continued to page 4.0	n care	

PAGE	06/26
PRINTED:	08/23/201

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED	): 08/23/201 APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		445264	B. WING_		1 00	[4E]0040
NAME OF	PROVIDER OR SUPPLIER	<del>, , , , , , , , , , , , , , , , , , , </del>	<del>'                                    </del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	<u>/15/2013</u>
			.			
LAUGH	LIN HEALTH CARE CE	NTER '	1	801 E MCKEE ST		
	1	·		GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(XS) COMPLETION EATE
F 241	Continued From page	, no 2		Continued from pag	e 3 of 19	
	· · · · · · · · · · · · · · · · ·	Ae o	F 24	planned according to their choi	CE.	
	dignity.			Se	eptember (	2013
F 244		N/ACT ON GROUP	F 244	4		7
SS≃D				483.15(c)(6) F 244 LISTEN/ACT (	ÖN	
	When a resident or must listen to the vis	family group exists, the facility was and act upon the		GRIEVANCE/RECOMMENDAT	ION	
	grievances and reco	mmendations of residents		Direction and an array of the second		1
	and families concern	ning proposed policy and		REQUIREMENT: When a residen	C OF	
	operational decision	s affecting resident care and		family group exists, the facility mus	E listen	
	life in the facility.	o and amount of the file		to the views and act upon the grieval recommendations of residents and fa	nces and	ĺ
				concerning proposed policy and ope	ammes	
	•			decisions affecting resident care and	ranonai	
	This REQUIREMEN	T is not met as evidenced		the facility.	. IIJ <del>e</del> M	
ł	by:			the langity.		
	Based on review of	Resident Council Minutes		POC:		
	and interview, the fac	cility failed to address		1. The facility will conduct initial		
}	grievances made du	ring Resident Council		periodic checks of each resident	2001 2001	
Į	meetings for six of th	e last seven months.		light for correct placement. The	s rem	
1				concerns of the residents from the	, ne	
}	The findings included	1:		resident council meeting will be	typed	
1				and sent to the Department Head	ds i	
-	Review of the Reside	ent Council Minutes dated		within 24 hours of the resident of		
Į	January 24, 2013, re	vealed "Nursing: There		meeting and the concerns will be	8	
	were two complaints	this month about night shift		investigated and addressed by th		
	CNAs (Certified Nurs	ing Assistants)not		Department Heads in a meeting		
	answering the call lig.	hts in a timely fashion		week. The results of the investig		
	(residents) were waiti	ng a long time after		and the interventions implement	ed will	
[ ]	answering the call ligi	hts before (CNA's were)	i	be brought before the resident co	ouncil	
	coming to take care o	or them"		in the next scheduled meeting.	i	
[	Review of Resident C	Signature 3-1-3	:	2. All resident grievances will be to	eated	
				with respect and an investigation	of	
	felt cell lights were es	vealed "NursingSome		each grievance will be conducted	l and	
	as they need to be by	t getting answered as soon		appropriate interventions will be	1	į
	onvarded to encreed	stanAll complaints	į	implemented.		ŀ
! !	ab ou coücelus''' Olmaidea to abblobil	ate departments. Will follow		3. The QA Nurse will be conducting	g	
- 1	ab ou opinellia	J		periodic assessment of call light		ļ
١.	Doubless of Double -4 C			placement, and if deficient practi	ce does	

Review of Resident Council Minutes dated March

Continue to page 5 of 19

		THE OBJECT OF THE OBJECT			ONIB NO	<i>෦</i> . ႮႸ <b>Კ</b> Წ-ႮႯႸႨ	
SIATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445264	B, WING	3	08	/15/2013	
	PROVIDER OR SUPPLIER IN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		, <u>10,2010</u>	
444	DI IA DE CA PINA AND	·		<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	IX (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
I I I I I I I I I I I I I I I I I I I	28, 2013, revealed residents said they their call light in their request this be discipled by their call light in their request this be discipled by their call light in their request this be discipled by their call light in their 2013, June 27, 2013 grievances related the resident's conconfirmed in a timely linterview with the Acquist 14, 2013, at room revealed there of the resident's conconfirmed no follow linterview with the Acquist 14, when grievances are meeting a copy of the emailed to all departing the acquisite with the Acquisterview with	"Nursing: 1. Couple of have not been able to reach it roomCouncil members used with the Director of  Council Minutes for May 23, 3, and July 25, 2013, revealed to the call lights not being y manner.  esident Council President on 1:10 p.m., in the resident's had not been any resolution cems. Continued interview up had occurred.  tivity Director in the Activity 2013, at 1:50 p.m., revealed a identified during the council e council minutes are ment heads. Continued tivity Director confirmed there low up completed for the tivity Director. Continued tivity Director revealed the ceived copies of the minutes are grievances.  ministrator on August 14, 1 the Administrator's office at Council minutes were	F 2	Continued from particular continued facility staff.  4. This process will be monitored both prector, Administration of the continued from the continue of the cont	ven to all d by the rs, tor, Social I members re being council	5, 20 <b>1</b> 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA EDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
·		445264	B, WING		08/15/2013
	PROVIDER OR SUPPLIER LIN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 E MCKEE ST GREENEVILLE, TN 37743	1 007332013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC (DENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
SS=E	confirmed the facility Resident Council gr 483.15(h)(1) SAFE/CLEAN/COMENVIRONMENT The facility must procomfortable and hor the resident to use he to the extent possible. This REQUIREMENT by: Based on observation and interview, the facility and interview of the dining at the findings included to be a staff members placed twenty of twenty-two residents if they prefer protectors during the consideration on Augusto 8:42 a.m., in the macility staff members on eight of eight observation on Augusto 8:42 a.m., in the macility staff members on eight of eight observation on Augusto Cobservation on Augusto Cobservatio	y had falled to act upon the ievances.  FORTABLE/HOMELIKE  vide a safe, clean, nelike environment, allowing is or her personal belongings e.  T is not met as evidenced on, review of facility policy, cility failed to maintain a e during dining activities in reas observed.  It:  st 12, 2013, from 12:20 to sin dining hall revealed facility dicothing protectors on residents without asking the erred to use clothing meal.  st 13, 2013, from 8:30 a.m. ain dining hall revealed placed clothing protectors rived residents without fithey preferred to use ring the meal.  at 14, 2013, at 5:00 p.m., in evealed clothing protectors	F 244	483.15(h)(1) F 252 SAFE/CLEAN/COMFORTABLE/F ELIKE ENVIRONMENT  REQUIREMENT: The facility must provide a safe, clean, comfortable and homelike environment, allowing the reto use his or her personal belongings to extent possible.  POC:  1. The facility will promote care for residents in a manner and in an environment that maintains or enheach resident's dignity. The CNA ask the residents in the main dining room if they prefer to use clothing protectors during meals.  2. Other residents in the facility, other the main dining area will be asked they prefer to use clothing protector during meals.  3. An in-service will be given to all mursing staff on the importance of asking residents before placing cloprotectors. This will be done in reof resident's dignity.  4. This process will be monitored by DON, ADON, Wing Managers, an Activity Director to assure respect resident's dignity. Periodic in-serv will be given to ensure this practice continues.	esident of the  ancos s will g er than if ours  thing spect
<u> </u>	n use for twenty-three	e of twenty-three residents.			

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		<u>1</u>
i	AND PLA	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
ı			445264	B WING	B, WING				
ŀ	NAME O	F PROVIDER OR SUPPLIER	-15204	25, 171110	STREET ADDRESS, CITY, S		08	3/15/2013	_
I					801 E MCKEE ST	IAIE ZIP CODE			
ŀ	LAUGE	ILIN HEALTH CARE CE	NTER		GREENEVILLE, TN 37	7743			
ľ	(X4) ID	SUMMARYSTA	TEMENT OF DEFICIENCIES	lD ID	<del></del>	LAN OF CORRECTION	st .	l over	
	PREFIX TAG	{EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF()	(EACH CORRECT)	TVE ACTION SHOULD	BE	COMPLETION	
		i	SO TO CHAIR THE HAT DAY TON	TAG		ED TO THE APPROPE FICIENCY)	SATE.	DATE	
	-		<del></del>	<del>                                     </del>				<del> </del>	-
	F 252	Continued From page	ge 6	F 2	52				
								1	
		Review of facility po	licy, Feeding the Resident,						Ì
		articles as indicated	revealeduse special	}					
		1							
		Interview with the Di	rector of Nursing (DON) on						
		August 15, 2013, at	3:20 p.m., in the DON's office had failed to ask each						l
		resident's permission	n prior to using the clothing					1	
	protectors prior to the application of the clothing protectors. Continued interview confirmed the facility had failed to maintain a homelike			· ·				Į	
			]				•	ļ	
		atmosphere in the m	naintain a nomelike Isin diping area	1					ĺ
	F 272	483.20(b)(1) COMPF	REHENSIVE	F 27	2 483 2005(0) 10 222 6	- California de la compansión de la comp	<b>.</b>		l
	SS=D			`-'	2 483.20(b)(1) F 272 C ASSESSMENTS	-Own.KEMENST.	VE,		I
	_	The facility must con	duct initially and periodically		DE05	<b></b>			İ
		l a comprehensive, ac	curate, standardized		REQUIREMENT: 1 conduct initially and 1	The facility must			l
		reproducible assess	nent of each resident's		comprehensive, accur	periodicany a rate, standardized			۱
		functional capacity.	i	l	reproducible assessme	ent of each resider	at's		ĺ
	ĺ	A facility must make a	a comprehensive		functional capacity.			j i	l
		assessment of a resi	dent's needs, using the		A facility must make	a comprehensive			
		resident assessment	instrument (RAI) specified		assessment of a reside	ent's needs, using !	<b>th</b> e	] :	l
	ļ	least the following:	sessment must include at		resident assessment in	istrument (RAI)			l
		Identification and den	nographic information;		specified by the State, include at least the fol	. The assessment i	must		
		Customary routine;			Identification and den	rographic informa	tion:		ĺ
		Cognitive patterns; Communication;			Customary routine;	,	,		
	]	Vision;			Cognitive patterns; Communication;				
	İ	Mood and behavior pa	atterns;		Vision;		i		
	}	Psychosocial well-beil	ng; ind structural problems;		Mood and behavior pa				ı
		Continence;	and substitutal problems;		Psychosocial well-beit		Ì		
	i	Disease diagnosis and	d health conditions;		Physical functioning a problems;	ng sericural		ļ	
		Dental and nutritional	status;	•	Continence;		ľ	1	
	}	Skin conditions;			Contin	ue to page 8 of 19	· · [		
_	1				t .		t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLU IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		<del>44</del> 5264	B. WING _		08/15/201:		
	PROVIDER OR SUPPLIER JN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIF 801 E MCKEE ST GREENEVILLE, TN 37743		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	the additional assest areas triggered by the Data Set (MDS); and	and procedures;  Ummary information regarding sment performed on the care the completion of the Minimum	F 27	Continued fr Disease diagnosis and health Dental and nutritional status. Skin conditions; Activity pursuit; Medications; Special treatments and proce Discharge potential; Documentation of summary regarding the additional asses performed on the care areas t completion of the Minimum I (MDS); and Documentation of participationssessment.	information ssmeut triggered by the Data Set		
i i	by: Based on medical reand interview, the factor and interview, the factor and interview, the factor and interviewed.  The findings included Resident #30 was ad 29, 2013, with diagnous Neck of Femur (hip from Mellitus.  Medical record review revealed on July 31, 2 he injectable anticoat medication. Continue order dated August 2, Physician ordered Aspused as a blood thing	mitted to the facility on June ses including Fractured acture) and Dlabetes  of the Physician's orders (013, the Physician stopped gulation (blood thinner) of review of the Physician's 2013, revealed the pirin 325 milligrams daily ter).	•	POC:  1. A head to toe assessment completed on resident #3 29, 2013, with no other b  2. All current residents on a medications have been as signs and symptons of ble  3. An in-service to all nursin conducted on side effects anticoagulation. A week assessment will be conducted on all residents. Current anticoagulation, including had their current care planticulate side-effect of med  4. The DON, ADON, Wing and/or designees will more assessments for residents anticoagulation therapy for and compliance on new acquarterly in coordination a schedule.	on August pruising noted, auticoagulation ssessed for eeding, ng staff will be to of ly skin cted by an RN residents on g aspurin, have ns updated to dication. Managers nitor with or accuracy dmissions and with MDS	2012	
F	Review of the care pla	n dated July 12, 2013,			September 6,	2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLJA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	<u></u> ,
· <del>- · · · · · · · · · · · · · · · · · ·</del>		445264	B. WING_		08/15/2013	Ł
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
F 279 SS=D	revealed "Observe purpura (bruises in areas (small blue of blood in urine, blood in the sputum), eleve abdominal pain, epi Observation on Aug the resident's room on the left hand and on the left arm. Intervealed the resider result of bumping the medications the resident "30"s if on the resident "30"s if on the resident "30"s if on the resident "50"s inches by 2 ½ inches "bumped my hand the Review of the Nurse 2013 through August documentation of the Interview on August the east nurse's designation of the Interview on August the east nurse's desident "50" on the resident of the Review of the Nurse (LPN #1) reversident "50" on Asignature the resident and arm. Continued bruises should have resident being on Asignature the Resident being on Asignature the Resident Deing on Asignatur	e for signs of active bleeding, the deep tissues), ecchymotic purplish bruises), hematoma, in stools, hemoptysis (blood ated temp, pain in joints, staxis (nose bleed)"  ust 12, 2013, at 3:00 p.m., in revealed a nickel sized bruises several penny sized bruises were a penny sized bruises were a penny and due to the dent received.  ust 14, 2013, at 3:15 p.m., from revealed a new bruise of hand/arm and due to the dent received.  ust 14, 2013, at 3:15 p.m., from revealed a new bruise of hand approximately 2 s. Resident #30 stated his morning."  Is Notes dated on August 1, at 13, 2013, revealed no eresident's bruising.  It 5, 2013, at 11:00 a.m., near a with Licensed Practical aled LPN #1 was the larse for that day and was a had bruises on the hand interview confirmed the been assessed due to the prin.  It DEVELOP	F 279		e the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIËR/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<u>, 00 ,</u> (
		445264	B. WING_		08/15/2013	į.
LAUGHI	PROVIDER OR SUPPLIER LIN HEALTH CARE CE	· · · · · · · · · · · · · · · · · · ·	-	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEË ST GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLET	
	comprehensive plan The facility must der plan for each reside objectives and timet medical, nursing, an needs that are ident assessment.  The care plan must to be furnished to at highest practicable p psychosocial well-be §483.25; and any se be required under §- due to the resident's §483.10, including th under §483.10(b)(4).  This REQUIREMEN' by: Based on medical re and interview, the fac plan of two (#6, #108) The findings includes Resident #6 was adm 26, 2013, with diagnor Removal of Malignan Weakness, and Place (NG) (for food/fluids).  Review of the Hospita July 26, 2013, reveale Physician's orders to and dry, rinse mouth	velop a comprehensive care nt that includes measurable ables to meet a resident's id mental and psychosocial ified in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and sing as required under revices that would otherwise 183.25 but are not provided exercise of rights under re right to refuse treatment is not met as evidenced ecord review, observation, sility failed to revise the care of thirty residents reviewed.  It is not the facility on July sees including Surgical to Neoplasm of the Mandible, ement of Nasal Gastric Tube at Patient Summary dated	F 279	Continued from page results of the assessment to develop, and revise the resident's comprehens of care.  The facility must develop a comprehens care plan for each resident that includ measurable objectives and timetables meet a resident's medical, nursing, an mental and psychosocial needs that are identified in the comprehensive assess.  The care plan must describe the service are to be furnished to attain or maintar resident's highest practicable physical mental, and psychosocial well-being a required under g483.25; and any servithat would otherwise be required under g483.25 but are not provided due to the resident's exercise of rights under g48 including the right to refuse treatment g483.10(b)(4).  POC:  1. The care plan of Resident #6 has a updated to reflect mouth care as on by MD. The care plan of Resident has been updated to reflect range a motion to affected arm per restoration to affected arm per restoration to affected arm per restorations program.  2. Residents with contractures will he their care plan assessed for appropriate resident #6 was receiving mouth as ordered by MD but intervention failed to be placed on care plan up admission, but the care plan is now updated to reflect mouth care.  Continue to page 11 of	review ive plan  ensive es to de esment.  es that in the ces t	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
<u></u>		445264	B, WING		08	/15/2013
LAUGHI	PROVIDER OR SUPPLIER		İ	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
	revealed no problem care for the resident observation on August a wheelchair with a little resident's room rawheelchair with the and fluids being adm (IV).  Interview on August the East Unit Manage condition "was very in on the Care Plan.  Resident #108 was a January 10, 2012, with Dementia, Seizure Di (loss of function on o Record review of the August 2013 revealed Program 3X wk (wee Review of the Care P 2012, revealed no introntracture.  Interview on August 1 the East Unit Manage confirmed the care plant of the Care P 2012, revealed no introntracture.	Plan dated July 26, 2013, is or approaches to provide 's healing mouth.  Just 12, 2013, at 10:30 a.m., in evealed the resident sitting in NG tube in place.  Just 13, 2013, at 9:00 a.m., in evealed the resident sitting in evealed the resident sitting in the NG tube no longer present inistered via Intravenous  Just 13, at 9:40 a.m., with the reconfirmed the resident's important" and not addressed dmitted to the facility on the diagnoses including isorder, and Hemiplegia ne side of the body).  Physician's orders for the section of the section	F 278	assessed for contractures and appropriate interventions place plan. All residents with altern feeding methods will be care p for appropriate mouth care upon admission and PRN. Current will be assessed quarterly accommodate the mouth of the DON, ADON, Wing Manand/or designee will monitor publication and appropriate intervention for two weeks and then quarterly a to MDS schedule. Current residents for mouth of the mouth of the mouth of the program and the probe monitored by the DON, AD Wing Managers and for design	I be ed on care ate alanned on residents ording to agers resent th care or the next according idents d in a access will ON,	3, 2013

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	445264	8. WING_		01	3/15/2013	
	NTER		801 E MCKEE ST			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
483.25 PROVIDE OF HIGHEST WELL BE Each resident must provide the necessary or maintain the high mental, and psychos	ARE/SERVICES FOR EING receive and the facility must ry care and services to attain est practicable physical, social well-being, in		483.25 F 309 PROVIDE CARE/SERVICES FOR HIGH WELL BEING REQUIREMENT: Each resident receive and the facility must provi necessary care and services to atta maintain the highest practicable ph mental, and psychosocial well-bein	must de the in or ysical,		
by: Based on medical reand interview, the factorized by the care presidents reviewed. The findings included Resident #30 was ad 29, 2013, with diagnowed of Femur (hip findellitus. Review of the Care Prevealed "Observe burpura (bruises in the bruises), blood in unitermophysis (blood in ain in joints, abdominated)" Observation on Auguste resident's room re	cord review, observation, cility failed to provide care as plan for one (#30) of thirty  : mitted to the facility on June ses including Fractured acture) and Diabetes  lan dated July 12, 2013, for signs of active bleeding, e deep tissues), ecchymotic urplish bruises), hematoma ne, blood in stools, the sputum), elevated temp, hal pain, epistaxis (nose et 12, 2013, at 3:00 p.m., in vealed a nickel sized bruise		further signs and symptons of as indicated on comprehensive plan. Complete skin assessme Wing Manager revealed no off issues.  2. A weekly head to too skin asses will be conducted by RN and resident's medical record.  3. An in-service will be given by Nurse to licensed nursing and onursing regarding important poside effects of amicoagulants.  4. The DON, ADON, Wing Mana and/or designees will conduct and and the same shall be side effects of an and the conduct and the same shall be same s	bleeding care at by the service of t	, 2013	
	PROVIDER OR SUPPLIER IN HEALTH CARE CE SUMMARY STAT (EACH DEFICIENCY REGULATORY OR IS  Continued From page 483.25 PROVIDE C. HIGHEST WELL BE Each resident must provide the necessa or maintain the higher mental, and psychos accordance with the and plan of care.  This REQUIREMENT by: Based on medical re and interview, the face directed by the care presidents reviewed.  The findings included Resident #30 was add 29, 2013, with diagnous leck of Femur (hip from the findings included Resident #30 was add 29, 2013, with diagnous leck of Femur (hip from the findings included accordance with the care presidents and included Resident #30 was add 29, 2013, with diagnous leck of Femur (hip from the findings included accordance with the care president #30 was add 29, 2013, with diagnous leck of Femur (hip from the findings in the finding in the fi	A45264  PROVIDER OR SUPPLIER  IN HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From page 11  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility falled to provide care as directed by the care plan for one (#30) of thirty residents reviewed.  The findings included: Resident #30 was admitted to the facility on June 29, 2013, with diagnoses including Fractured leck of Femur (hip fracture) and Diabetes Mellitus.  Review of the Care Plan dated July 12, 2013, evealed "Observe for signs of active bleeding, nurpura (bruises in the deep tissues), ecchymotic reas (small blue or purplish bruises), hematoma bruises), blood in urine, blood in stools, emoptysis (blood in the sputurn), elevated temp, ain in joints, abdominal pain, epistaxis (nose leed)"  Observation on August 12, 2013, at 3:00 p.m., in the resident's room revealed a nicket sized bruise in the left hand and several penny sized bruises in the left hand and several penny sized bruises.	PROVIDER OR SUPPLIER  IN HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, observation, and interview, the facility failed to provide care as directed by the care plan for one (#30) of thirty residents reviewed.  The findings included:  Resident #30 was admitted to the facility on June 19, 2013, with diagnoses including Fractured leck of Femur (hip fracture) and Diabetes in the deep tissues), ecchymotic reas (small blue or purplish bruises), hematoma bruises), blood in urine, blood in stools, emoptysis (blood in the sputurn), elevated temp, ain in joints, abdominal pain, epistaxis (nose leed)"  Observation on August 12, 2013, at 3:00 p.m., in the resident's room revealed a nickel sized bruise	A BUILDING  A SULTING  A BUILDING  A BUILDING  A BUILDING  B WING  STREET ADDRESS, CITY, STATE, ZIP CODE  801 E MCKEE ST  GREENEVILLE, TN 37743  BY PROVIDER OR SUPPLIER  IN HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREGODED BY FULL REGULATORY OR ISC IDENTIFYING WERDRAMTON)  Conflinued From page 11  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, manuell, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  REQUIREMENT: Bach resident receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, manuell, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment with the comprehensive assessment with the comprehensive assessment with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment with plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment and plan of care.  POC:  1. Rosident #30 has been assessed with the comprehensive assessment with an an adverted to the skin asse will be conducted by RN and n resident's required.  A meetly head to toe skin asse will be conducted by RN and n resident's redical record review, observation and/or designess will conduct a	A BULDING  A BULDING  A BULDING  A BULDING  A BULDING  A BULDING  STREET ADDRESS, CITY, STATE, ZIP CODE  BUT AMCKEE ST  GREENVILLE, ITN 37743  SUMMARY STATEMENT OF DESIGNATION  SUMMARY STATEMENT OF DESIGNATION  (EACH DESIGNATION MUST BE PRECEDED BY FULL  REGULATORY ON INST BE PRECEDED BY FULL  REACH CORRECTIVE ACTION SHOULD BE  CARENSBERY UCES FOR HIGHEST  WELL BEING  REQUIREMENT: Bach resident must receive the time the eccessary care and services to attain or maintain the highest practicable physical, month, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  PROCI:  1. Rosident #30 has been assessment by Wing Manager revealed no other skin issues.  2. A weekly head to too skin assessment will be conducted by RN and noted to resident's modical record.  3. An in-service will be given by QA Nurse to licensed musting map ratio protting and CONA nursing regarding important potential side effects of amicoagularus.  4. The DON, ADON, Wing Managers and report any problems to their obarge nurse.  September (  1. Rosident #30 has been assessment by Wing Managers and CONA.  3. An in-service will be given by QA Nurse to licensed musting important potential side effects of amicoagularus.  4. The DON, ADON, Wing Managers and report an	

	STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	445264		8, WING_		08/15/2013	
NAME OF PROVIDER OR SUPPLIER  LAUGHLIN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 309	thought the bruises hand/arm and due to received.  Observation on Augmear the resident's riginches by 2½ Inches "bumped my hand to Review of the Nurse 1, 2013 through Augmentation of the Interview on August the east nurse's des Nurse (LPN #1) reveresident's Charge N	were a result of bumping the to the medications the resident fust 14, 2013, at 3:15 p.m., room revealed a new bruise th hand, approximately 2 s. Resident #30 stated his morning."  b's Notes dated from August gust 13, 2013, revealed no e resident's bruising.  15, 2013, at 11:00 a.m., near sk with Licensed Practical ealed LPN #1 was the urse for that day and was	F 30	9		
SS=D	and arm.  Observation of the reat 1:30 p.m., near the East Unit Manager in was unaware of the chands and the left ar Interview on August east nurse's desk wit confirmed the reside anticoagulant and the for side effects of the 483.25(h) FREE OF HAZARDS/SUPERV.	15, 2013, at 1:40 p.m., at the the East Unit Manager nt received Aspirin as an e resident was not monitored emedication.  ACCIDENT ISION/DEVICES  ure that the resident as free of accident hazards	F 323	483.25(h) F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICE REQUIREMENT: The facility must entitle that the resident environment remains a Continue to page 14 of	ES wswe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED
		445264	B. WING	) <u></u>	_ 08	/15/2013
	PROVIDER OR SUPPLIER JN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STA 8M E MCKEE ST GREENEVILLE, TN 377	ATE, ZIP CODE	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLA IX (EACH CORRECTIVE CROSS-REFERENCEI	AN OF CORRECTION I'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	adequate supervision prevent accidents.  This REQUIREMENT by: Based on medical rinvestigation, observing facility failed to implest two falls for one (#78). The findings included Resident #75 was accepted 22, 2012, with diagnost Depression, Anxiety, Fractures, and Glaud Record review of a fact August 8, 2013, revestigation on the floor of the found. Further review revealed "Additional aken to prevent recordater and oriented). Eassistance"  Record review of a fact august 10, 2013, revestiting on mat on floor floor floor on the floor of the	T is not met as evidenced ecord review, review of facility ration, and interview, the ement new interventions after 5) of thirty residents reviewed.  It is not met as evidenced ecord review, review, the ement new interventions after 5) of thirty residents reviewed.  It is not met as evidenced in the facility on June personal with Rib econd.  It is not met as evidenced, the existence is a collity on June personal in the existence in the existenc	F 3	Continued of accident hazards as resident receives adeq assistance devices to p  POC:  1. Resident #75 has closer to the nursicare plan has been interventions revise.  2. Licensed nurses hor the fall prevent assessing residents new interventions plan.  3. The DON, ADON and/or designees we audits of resident finterventions week then quarterly in accesses sments.  4. The DON, ADON, and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we and/or designees we are severed.	I from page 13 of 19 is possible; and each mate supervision and prevent accidents.  been moved to a room ing station. Resident in reviewed and sed. have been re-educated tion program and is post-fall for possible and updating care if, Wing Managers will complete random falls with care plan dy for one month, ecordance with MDS	, 2013
i) to	njuriesAdditional co	e: Resident encouraged to		'		

	STATEMEN AND PLAN	¥T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			445264	B, WING	B, WING		
NAME OF PROVIDER OR SUPPLIER  LAUGHLIN HEALTH CARE CENTER			NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743	08/15/2013	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE FRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECTIO	DIBE COMPLETION	
		safety"  Review of the currer 2013, revealed approto alert staff of unass safety issues at time instuctto usecall assistanceStaff assassist x1 for ambulating lowest position when matComplete fall riper facility protocalI when not wearing she fallsHavewear no ambulatingObserve functional statusOb when ambulating,"  Observation on Augustical statusObservation on Augusting	at Care Plan dated July 10, paches "Bed and w/c alarm sisted risingis unaware of sCall light within reach. light for staff sist x1 for transfers, staff ion, walker for stability, Staff . Continent of bowelBed inis in bed with bedside sk assessments routinely Havewear gripper socks best to help prevent n-skid shoes when a for decrease or loss of serve for gait unsteadiness	F 3:	23		
		a low bed with the cal mat beside the bed.	evealed the resident lying in I light within reach and a 5, 2013, at 10:15 a.m., at				
	F 371 4	the east nurse's desk confirmed no new inte to prevent another fall and August 10, 2013, 483,35(i) FOOD PRO	with the East Unit Manager erventions were put in place after the August 8, 2013, falls. CURE,	F 37	483.35(I) F 371 FOOD PROCURE,		
	() ()	authorities; and	sources approved or y by Federal, State or local tribute and serve food		STORE/PREPARE/SERVE-SANITA  REQUIREMENT: The facility must- (1) Procure food from sources approve considered satisfactory by Federal, or local authorities; and (2) Store, prepare, distribute and serve under sanitary conditions.  Continue to page 16 of 1	d or State	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	······································	445264	B. WING	·	08/15/2013	
	F PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743	1 -1///	
(X4) ID PREFD TAG	( [ (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLETION	
F 372 SS=E	This REQUIREMENty: Based on observation failed to store plates out of date milk, and a sanitary manner. The findings included Observation with the during the initial tour a.m., revealed two wregular plate in the place of the plate on August 11 had a pink colored sufficient with a use by date opened on August 11 had a pink colored sufficient with the Assigning the observation be dry before storage the milk was out of date the residents, and ice slide was unsanital 483.35(i)(3) DISPOSI PROPERLY	T is not met as evidenced on and interview, the facility in a sanitary manner, discard maintain the ice machine in d:  Assistant Dietary Manager on August 12, 2013, at 9:45 et divided plates and one wet ate warmer; the reach in the container of buttermilk, ½ to of August 6, 2013, dated as 2013; and the ice machine obstance on the ice slide.  Assistant Dietary Manager of August 6, 2013, dated as 2013; and the ice machine obstance on the ice slide.	F 372	Continued from page 1:  POC:  1. No residents were found to be affine by this citation.  2. The wet items were immediately removed, the buttermilk was dispost of immediately and the ice machine comptled, the ice disposed of and to machine was cleaned and sanitized bleach, so no residents have the potential to be affected by this cit.  3. The dish machine was repaired on August 13, 2013, and if any wet it are found, they will be immediate removed and re-washed and sanitianed air dried. The Dietary staff we serviced on how to read expiration and the proper cleaning of all equipment. Items are checked by Dietary Supervisors prior to each if for use by dates. The ice machine be emptied and cleaned twice a mean A bacteria growth prevention systetice machines will be installed. Die Supervisors will check the above it.  4. The Dietary Supervisors will inomiassure plates are stored in a sanitar manner, out of date items are disceand the ice machine is maintained sanitary manner.	oscd the was the ice d with ation. Items ly ized as in- a dates meal will onth. em in etary tems. itor to y urded in a ember 6, 2013	
	This REQUIREMENT by:	is not met as evidenced		POC:  1. No residents were affected in this  Continue to page 17 of		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		445264	B. WING _	<u> </u>	08/15/2013
NAME OF PROVIDER OR SUPPLIER  LAUGHLIN HEALTH CARE CENTER				SYREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 372	failed to provide in garbage appropria The findings included the findings included the findings included the finding dock reveloped the dumpster to the dumpster to the dumpster to the dumpster to the observation reveation reveation reveation reveation in the seam of open area approximately manager of intact for approved the finding for a portion of the facility must be facility must be facility must be facility must be facility must be facility must be facility;  (2) Decides what should be applied.	ation and interview, the facility stact dumpsters to dispose of tely for two of two dumpsters.  Itel:  The Assistant Dietary Manager 3, at 4:30 p.m., near the aled one dumpster had white in two areas on the bottom of the ground. Continued the second dumpster had a in the right side bottom with an imately 2 inches by 5 inches interview with the Assistant confirmed both dumpsters were opriate disposal of garbage.  IN CONTROL, PREVENT Setablish and maintain an Program designed to provide a comfortable environment and the development and transmission fection.	F 4	Continued from page citation.  2. No residents have the potential traffected by this citation.  3. A Welding Co. was contacted or August 27, 2013 by the Mainter Director to repair the current du Capital Budget request has been for a new Trash Compactor and purchased when funding is approand available. All staff have been reminded and in-serviced, and simade to be posted to empty all containers prior to placing in the cans.  4. The facility Maintenance Technand Dietary Supervisors will may for proper integrity of dumpster appropriate disposal of garbage	n nance mpsters. In made will be woved en nician onitor is for the ptember 13, 2013  ROL, st Control, sanitary o help mission of the phission
	(b) Preventing Sp (1) When the Infe	•		<ul> <li>(2) Decides what procedures, such isolation, should be applied to individual resident; and</li> <li>(3) Maintains a record of incidents</li> </ul>	an and

STATEMEN AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY
		A SOUTH FOR TON HOWINGERC	A BUILDING	G	COMPLETED
NAME OF	DDO/2000 OF OUR	445264	B. WING_		08/15/2013
	PROVIDER OR SUPPLIER  JN HEALTH CARE CE	ENTER	ł	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	BE COMPLETION
	prevent the spread isolate the resident.  (2) The facility must communicable disert from direct contact will tradict to direct contact will tradict from direct contact will tradict from direct contact will tradict from direct contact will tradict from the facility must hand washing is indiprofessional practice (c) Linens  Personnel must han	esident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ensmit the disease. require staff to wash their ect resident contact for which leated by accepted	F 441	<ul> <li>(b) Preventing Spread of Infection</li> <li>(1) When the Infection Control Progression to prevent the spread of infection, the facility must isolate resident.</li> <li>(2) The facility must prohibit employ with a communicable disease or infected skin lesions from direct owith residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to y their hands after each direct reside contact for which hand washing is indicated by accepted professional practice.</li> </ul>	the  ees  contact  ect  wash
	by: Based on observation failed to provide hand residents with meals. The findings included Deservation on Augustie (RA #1) was assured in the spoon and beservation revealed spoon and fork to fee esident's mouth with observation revealed coiled lid of a sippy outside out the cup, possery replaced the lid,	st 12, 2013, at 12:00 p.m., in room revealed Restorative sisting one resident with		<ul> <li>(c) Linens</li> <li>Personnel must handle, store, process a transport linens so as to prevent the spr of infection.</li> <li>POC:</li> <li>1. Restorative aids and CNAs will be services on correct procedure for h washing when assisting different residents.</li> <li>2. The DON, ADON, Wing Manager and/or designees will monitor each dining area for other residents that could be affected.</li> <li>3. An in-service will be conducted for nursing staff on proper procedure if hand washing when assisting more one resident. CNAs and restorative will be provided small bottles of hand continue to page 19 of</li> </ul>	rail or then e aids and

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445264			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED			
			445264	B. WING_		08/	15/2013	
	NAME OF PROVIDER OR SUPPLIER  LAUGHLIN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  801 E MCKEE ST  GREENEVILLE, TN 37743				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE			
		first resident.  Interview on August RA#1 outside of the the hands were not soiled sippy cup of a continuing to feed the Observation of the way August 13, 2013, at Nursing Assistant (Cat table number three CNA#2 put a spoom mouth, wiped the resident. Continued #2 alternated between sanitizing hands between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #2 alternated between the continued #4 alternated #4 alternated betw	tontinued to assist/feed the 15, 2013, at 10:00 a.m., with a conference room confirmed sanitized after handling the mother resident and a first resident. West wing dining room on 12:20 p.m., revealed Certified NA #2) feeding two residents are. Observation revealed ful of food in a resident's sident's mouth with a napkin, the process with another observation revealed CNA and the two residents without ween contact of the 2 at the time of the dithe hands were not	F 44	senitizer for cleaning hat assisting more than one:  4. The DON, ADON, Wing and/or designees will me each meal for one week monthly for six months a findings to the QA Complianther recommendations found.	nds when resident. g Managers onitor process and then and present mittee for	i, 2013	